

02/16/06

Web Announcement 74

FH-40 Medicare Crossover Claim Form Discontinued:

The implementation of new billing procedures for claims with Third Party Liability (TPL) has rendered the FH-40 Medicare Crossover Claim Form obsolete. Form FH-40 was discontinued for CMS-1500 claim forms on 01/13/06 and will be discontinued for UB-92 claim forms on 02/24/06.

Effective on the above dates, claims that “cross over” from Medicare should be billed the same as any other claim with TPL, i.e., forwarded electronically from your Medicare carrier or submitted on the appropriate paper claim form with the Explanation of Benefits (EOB) attached.



First Health Services Corporation
Medicare Crossover Claim Form

1. Medicare Provider ID Number
2. Recipient Name (Last, First)
3. Type of Crossover Claim (please check one):
 Submitting a Medicare Crossover Claim
 Requesting a Medicare Claim Adjustment (RRC)
 Voiding a Medicare Claim (RRC)
4. Medicare Recipient ID Number
5. Medicare Recipient TIC Number
6. Patient Account Number (Optional)
7. Primary Liability Adjustment (check one):
 No Other Coverage
 Other TPL Coverage
 Billed and Paid
8. Type of Medicare Coverage (Enter A, B, or C on the line below):
Medicare Part _____
9. Accident/Emergency Indicator:
 Accident
 Emergency
 Other
10. Statement Cover Period (MMDDYYYY) - Begin Date: 11 / 30 / 1999 End Date: / /
Line 1
11. Diagnosis
12. Place of Service
13. Type of Service
14. Procedure Code
15. Inpatient/Outpatient/Study
16. Admission Date (if applicable)
17. Charges to Medicare
18. Allowed by Medicare
19. Paid by Medicare
20. Deductible
21. Coinsurance
22. Paid to Carrier Other Than Medicare
Line 2
11. Diagnosis
12. Place of Service
13. Type of Service
14. Procedure Code
15. Inpatient/Outpatient/Study
16. Admission Date (if applicable)
17. Charges to Medicare
18. Allowed by Medicare
19. Paid by Medicare
20. Deductible
21. Coinsurance
22. Paid to Carrier Other Than Medicare
Line 3
11. Diagnosis
12. Place of Service
13. Type of Service
14. Procedure Code
15. Inpatient/Outpatient/Study
16. Admission Date (if applicable)
17. Charges to Medicare
18. Allowed by Medicare
19. Paid by Medicare
20. Deductible
21. Coinsurance
22. Paid to Carrier Other Than Medicare
For Adjustment Requests and Void Only
23. Original ICD-9
24. Reason Code
25. Provider Remarks
This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will come from federal and state funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under applicable federal or state laws.
26. Provider Signature
27. Date
28. FAX
29. MAIL
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Please review the revised billing information in the [Claim Form Instructions](#).